Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
PROVIDENCE HEALTH CENTER

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-14-2258-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
MARCH 25, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Since TDI moved to a 200% of MAR for outpatient services on 3/1/08 for hospital claims, we have reviewed the Medicare allowance and decided the insurance reimbursement does not meet this criteria. Medicare would have allowed this facility $550.20 for the MAR at 200%. This was denied for timely filing but the reconsideration request was sent with the hospital system notes showing that this was billed to Broadspire on 8/5/13. Based on their payment of $0.00, a supplemental payment of $500.20 is due."

Amount in Dispute: $500.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please allow this to service as our response for the above captioned medical fee dispute resolution. The bill in question has been paid. We have attached a screen shot of the check and the EOB."

Response Submitted by: BROADSPIRE

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 17, 2013	Emergency Room Services	$500.20	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the guidelines hospital outpatient reimbursement.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 663-022 – Based on Fee Schedule Guidelines, bills submitted after the 95th day after the date of service are disallowed.
   - B4 – Late filing penalty.
   - 887-005 – The time for filing has expired.
   - 900-001 – O – Denial after reconsideration/based on further review, no payment is warranted.

- W1 – Workers' compensation jurisdictional fee schedule adjustment.
- W4 – Workers' Compensation Medical Treatment Guideline Adjustment.
- 595-001 – The reimbursement amount is based on the Medicare reimbursement plus theperventage increase specified by the state.
- 983-001 – Upon further review additional payment is warranted.

Issues

1. Did the requestor receive payment for the date of service and services in question?
2. Is the requestor entitled to reimbursement?

Findings

1. The services in dispute were initially denied for timely filing; however, review of the respondent's response to the submitted dispute finds a screen shot of check number 2870133764 in the amount of $564.25. The respondent also submitted an EOB showing payment was submitted for the disputed CPT Codes 73110-RT and 99284-25; and HCPCS Code L3908, which is not in dispute. Therefore, in accordance with §134.403 reimbursement was made for the outpatient emergent services in dispute.
2. Because the respondent has submitted documentation supporting reimbursement for the disputed services has been made, no additional amount is owed.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 19, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.